**AN OVERVIEW OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
AND SYSTEMS COORDINATION STRATEGIES**

SECTION 1: EVIDENCE-BASED AND PROMISING PRACTICES

Federal research and demonstration programs and the experience of hundreds of community-based providers have shown that the services described below help decrease psychiatric symptoms and substance use and increase residential stability for people with mental and addictive disorders. States and communities can adopt or adapt these practices to local needs.

Outreach and Engagement

Compared to people with serious mental illnesses and substance use disorder who are housed, individuals who are homeless are likely to be more severely impaired, to have more basic service needs, and to be unwilling or unable to seek treatment.[1] If they won't seek help, help has to go to them.

Once considered to be a nontraditional service, outreach is now recognized to be the initial and most critical step in connecting or reconnecting a person who is homeless to needed health, mental health, substance abuse, and social services and to housing. However, people who are homeless are not focused initially on receiving mental health or substance abuse treatment. Outreach workers must meet them "on their own terms and on their own turf."[2] They find people on the streets, under bridges, in parks, and in shelters, and they focus on meeting the individual's immediate needs for food, clothing, and shelter.

This process of engagement is essential to developing the trust and rapport needed to help individuals accept more long-term services, which is the ultimate goal of outreach efforts. Regardless of how or where outreach is provided, successful outreach workers must adopt a non-threatening approach; be flexible in the number and types of services offered, as well as the manner in which they are provided; and make numerous contacts over extended periods of time.[3] Outreach workers who have been homeless and are recovering from mental illnesses and substance use disorders may be especially effective at engaging individuals who are difficult to reach.[4]

What the Research Says. *Outreach, whether in shelters or on the streets, is effective.*[5] Given the opportunity, most people with serious mental illnesses and substance use disorders who are homeless are willing to accept treatment and services voluntarily. Indeed, skilled outreach teams eliminate the need for involuntary treatment for most individuals. A study of individuals enrolled in the ACCESS program who were contacted through street outreach revealed that even individuals with the most severe disorders who are the most reluctant to accept treatment will enroll in services and show improved outcomes when served by an outreach team.[6]

A study of the effectiveness of outreach with homeless people who abuse substances found that nearly half of outreach contacts became enrolled in services.[7] More important, those contacted through outreach had significantly higher levels of substance abuse than walk-in clients, and were more likely to be engaged in HIV risk behaviors. This indicates that outreach can be successful in reaching those individuals most in need of services. Consistent, caring, personal relationships, and the introduction of services at the client's pace, are critical elements in outreach efforts designed to engage people who are homeless into treatment. Unfortunately, few health insurance programs consider outreach to be a reimbursable expense. Outreach is the most common service offered by providers who receive Projects for Assistance in Transition from Homelessness (PATH) funds; for more than one-third of these providers, PATH funds are their only source of outreach revenues.

Housing with Appropriate Supports

People without homes need housing. That almost goes without saying. Yet several other factors are at work. First, the type and range of housing services must be appropriate to meet individual needs. For example, housing for people with serious mental illnesses historically has been in some type of congregate setting such as a group home, but preference studies show that people with serious mental illnesses want to live in integrated, regular housing rather than in segregated, mental health programs.[8]

Initially, some individuals, especially those with substance use disorders, may require a type of low-demand housing, such as a Safe Haven,[9] to help them re-engage in services. Indeed, while the provision of housing increases retention in substance abuse treatment for people who are homeless, "the increase tends to be nullified with the housing is bundled with high-intensity services."[10] Ultimately, people with substance use disorders need safe, sober housing to help them maintain their treatment gains.

Second, housing is necessary but not sufficient to help individuals with mental and addictive disorders who have been homeless regain psychiatric and residential stability and maintain sobriety. They require unique, flexible supportive services that are optional, i.e., that are not a requirement to access housing. The Corporation for Supportive Housing defines such services as those that are 1) designed to maximize independence; 2) flexible and responsive to individual needs; 3) available as and when needed; and 4) accessible where the individual lives.[11]

What the Research Says. *Providing supportive services to people in housing is effective in achieving residential stability, improving mental health and substance abuse, and reducing the costs of homelessness to the community.*[12] Most people with serious mental illnesses who are homeless prefer supportive housing, and they do well, despite widely held assumptions about the need for more structured housing for people with the most severe disorders.

In fact, many people can move directly from homelessness to independent housing with supports. However, the transition from homelessness to housing is a critical time that needs intensive support and attention. Many individuals who have lived on the streets feel isolated and disoriented when they begin living inside, and services may have to be increased, rather than decreased, at this time.[13] For example, people with substance use disorders whose friends include members of the "bottle gang" with whom they drink may prefer a return to the streets where they have some perceived level of social support.[14]

Finally, research also reveals that consumer choice in housing is critical for success, and that housing subsidies are a key component to making housing affordable for this group. However, as noted previously, subsidies do not guarantee that housing will be available.

Multidisciplinary Treatment Teams/Intensive Case Management

People with serious mental illnesses and substance use disorders who are homeless have complex problems that require comprehensive treatment and services. A multidisciplinary treatment team provides individuals with a type of "one-stop shopping" to arrange for or provide all of the services they require.

Assertive Community Treatment (ACT) is a good example of this approach. Begun in the late 1970s with the Program of Assertive Community Treatment in Madison, Wisconsin, ACT is acknowledged to be a successful approach to providing a full range of community-based services to people with serious mental illnesses and substance use disorders. ACT teams feature a multidisciplinary group of mental health, substance abuse, and social service specialists who provide, or arrange for, each individual=s clinical, housing, and rehabilitation needs. Client/staff ratios are low (typically 10 to 1), and services are available around the clock.

The ACT model has been modified successfully to meet the needs of people who are homeless. For example, because some people who have been homeless have trouble forming trusting relationships, they may be assigned to one or two members of the team, rather than the whole team. All team members are knowledgeable about each client, however.[15] Many ACT teams use mobile outreach to serve people who are unwilling or unable to go to them.

What the Research Says. *ACT and similar models of intensive case management reduce inpatient hospitalization, decrease substance use and psychiatric symptoms, and increase community tenure for people with serious mental illnesses and substance use disorders.* Regular assertive outreach, lower caseloads, and the multidisciplinary nature of the services available on these teams lead to positive treatment and housing outcomes.[16]

The provision of substance abuse services on an ACT team is a critical ingredient for success. Research indicates that ACT is not effective in reducing substance use when the substance abuse services are brokered to other providers and not provided directly by the ACT team.[17]

Integrated Treatment for Co-Occurring Disorders

Mental health and substance abuse providers frequently cite the problem of co-occurring psychiatric and substance use disorders as the most difficult situation they face. Individuals with co-occurring disorders tend to be more symptomatic, to have multiple health and social proble ms, and to require more costly care.[18] They are at risk for homelessness and incarceration. Among people with serious mental illnesses who are homeless, approximately half have a co-occurring substance use disorder.[19]

Providers struggle to fund and develop effective approaches for treating people with co-occurring disorders who are homeless. Three common approaches include the following:

- **Sequential approach**. The individual receives treatment first for one disorder and then for the other, with treatment provided by two different agencies.

- **Parallel approach**. Two different providers, one offering mental health services and the other providing substance abuse treatment, treat the individual simultaneously. However, treatment plans are rarely coordinated.

- **Integrated services approach**. The individual participates in concurrent and coordinated clinical treatment of both psychiatric and substance use disorders provided by the same clinician or treatment team in a single agency. Unfortunately, such programs are rare.

What the Research Says. *An integrated approach is superior to a parallel or sequential approach to treatment for people who have co-occurring serious mental illnesses and substance use disorders*. Integrated treatment reduces alcohol and drug use, homelessness, and the severity of mental health symptoms.[20] Though people with co-occurring disorders who are homeless drop out of treatment programs in high numbers, the CMHS/CSAT Collaborative Demonstration Program for Homeless Individuals had retention rates as high as 74 percent in its programs that offered integrated treatment. Individuals did best when their treatment was combined with other services such as housing, legal services, and income support. Further research is needed to confirm the effectiveness of this approach for people with less severe disorders.

Motivational Interventions/Stages of Change

Many homeless individuals with substance use disorders are not ready to benefit from abstinent-oriented programs.[21] Further, they also may lack the motivation to engage in active treatment. Motivational interventions emerged in the substance abuse field[22] and have been adapted for people with serious mental illnesses and co-occurring disorders, as well as for people who are homeless.

Motivational interventions include a range of clinical strategies designed to enhance motivation for change, including counseling, assessment, multiple sessions, or brief interventions. Five key principles of motivational enhancement include the following:[23]
- Express empathy
- Note discrepancies between current and desired behavior.
- Avoid argumentation.
- Refrain from directly confronting resistance.
- Encourage the individual's belief that he/she has the ability to change.

Further, motivational enhancement techniques must be matched to the client's stage of recovery and are often integrated as part of the Stages of Change Model.[24] This model describes predictable stages of change for people with substance abuse disorders from *precontemplation* to *contemplation, determination, action, maintenance*, and *relapse prevention*.

What the Research Says. *Research has demonstrated that motivational enhancement techniques are associated with greater participation in treatment and positive treatment outcomes*. These outcomes include reductions in consumption, increased abstinence rates, social adjustment, and successful referrals to treatment.[25] A positive attitude toward change and a commitment to change are also associated with positive treatment outcomes.[26]

Modified Therapeutic Communities

Therapeutic communities (TCs) have been implemented as a method for addressing substance abuse disorders for more than 30 years. The concept is based on a clearly defined theoretical model that views drug abuse as a disorder of the whole person, requiring a focus on conduct, attitudes, moods, values, and emotional management. The community is the therapeutic method in a TC.

Modified Therapeutic Communities (MTCs) adapt the principles and methods of the TC to the needs of individuals with co-occurring psychiatric disorders, as well as those who are homeless. Key modifications for people with co-occurring disorders include increased flexibility, decreased intensity, and greater individualization.[27] MTCs for people who are homeless, often developed in shelter settings, incorporate services to address clients' multiple needs, such as education, vocational, legal, and housing placement services.[28]

What the Research Says. *Recent studies of the MTC approach reveal significant decreases in drug use and criminal activity, and increases in psychological functioning and employment.[29]* MTCs tend to result in more positive outcomes for individuals with the most severe psychiatric disorders, and those who remain in treatment for longer periods of time.[30] Several studies have found MTCs to be cost-effective relative to the provision of services-as-usual.[31]

Self-Help Programs

Self-help programs represent a central feature of most substance abuse treatment plans and have recently also become an important source of support for individuals with mental disorders. During the past decade, dual recovery/self-help programs have also emerged as an important adjunct to treatment for people in recovery from co-occurring substance abuse and mental disorders.[32]

Self-help approaches have their roots in Alcoholics Anonymous (AA) and have grown to address a wide variety of addictions. Narcotics Anonymous and Cocaine Anonymous are two of the largest self-help organizations in the area of chemical addictions.[33] Recovery Anonymous and Schizophrenics Anonymous support individuals with mental disorders.[34]

Self-help programs typically include the AA 12-step method, with a focus on developing personal responsibility within the context of peer support. However, specific applications may vary according to the needs and orientation of individuals and agencies/communities. Secular groups emphasize individual empowerment without focusing on the spirituality of the 12-step approach. Perhaps because of their low cost, and the fact that they provide an important source of support, self-help programs are among the most commonly used outpatient services for people with substance abuse disorders who are homeless.[35]

What the Research Says. *Self-help programs decrease inpatient treatment and substance use and increase self-esteem for people with mental and addictive disorders.* Individuals with mental illnesses in self-help groups report greater-self esteem, fewer hospitalizations, and better community adjustment.[36] People with co-occurring mental and addictive disorders who are homeless experience a greater decrease in substance use when they have a high level of participation in self-help groups.[37]

Self-help groups specific to co-occurring disorders can be an important adjunct to recovery for people who have both a mental and addictive disorder. One study found that people with higher levels of support and greater participation in dual recovery programs reported less substance use and mental health distress and higher levels of well-being.[38] These results did not hold true for people with co-occurring disorders who participated in the more traditional single-focus, self-help groups.

Involvement of Consumers and Recovering Persons

Individuals recovering from serious mental illnesses and substance use disorders play an increasingly important role in helping empower their peers to recover. Indeed, the social model approach to recovery from substance use disorders is built on the belief that individuals in recovery can help each other as much, if not more, than

professional staff. People with mental and addictive disorders who have been homeless may be especially effective in reaching their peers who are reluctant to seek help. Shared experiences between prospective clients and workers may ease the engagement process.

Some unique characteristics of staff in recovery and those who have been homeless include the following: their knowledge of the service system; their street smarts; their ability to develop alternative approaches; their flexibility, creativity, and patience; their understanding of an individual's basic needs and preferences; and their ability to build rapport with people who are homeless. Consumers and recovering persons serve as positive role models, are a major force in the elimination of stigma and discrimination, and make good team members.[39]

Programs run by consumers and recovering persons—including drop-in centers, recovery support programs, case management programs, outreach programs, businesses, employment and housing programs, and crisis services— may be more "user-friendly" for people who are homeless or at risk of homelessness. The focus of service delivery in these organizations is on choice, dignity, and respect.[40] Further, such programs provide meaningful work for consumers and recovering persons. Staff in recovery from mental and addictive disorders, and those who have been homeless, also enhance the sensitivity of the system to the needs of their peers.

Finally, consumers and recovering persons should be actively involved in the design, implementation, and evaluation of community mental health and substance abuse services. They make valuable members of planning councils and advisory boards. People who were homeless can make equally important contributions to the development of services for people who are currently homeless.

What the Research Says. *Consumers and recovering persons can make a unique and valuable contribution as program and agency staff.* In particular, consumers and recovering persons have experiences and characteristics that enhance their ability to provide services to individuals who are homeless.[41] Programs must be prepared to support staff in recovery with adequate supervision and workplace accommodations, if necessary, and to educate and train other staff about employment for consumers and recovering persons.[42]

Prevention Services

Services that prevent people with serious mental illnesses and substance use disorders from becoming homeless in the first place should be a critical component of a community's plan to end homelessness. In its 1992 report, *Outcasts on Main Street*, the Federal Task Force on Homelessness and Severe Mental Illness called prevention efforts both humane and cost-effective.[43] Two years later, with publication of *Priority: Home! The Federal Plan to Break the Cycle of Homelessness*, the Interagency Council on Homelessness proposed a two-pronged approach to address homelessness: 1) expanding services to help those who have become homeless, and 2) addressing structural inadequacies in housing and social services to help prevent people from becoming homeless.[44]

Strategies designed to prevent homelessness among people with mental and addictive disorders must be designed to *reduce risk factors*, such as lack of treatment for co-occurring disorders, which make individuals more susceptible to becoming homeless. Further, program planners and providers must work to *enhance protective factors*, such as supportive services in housing, which will mitigate against homelessness among people who are vulnerable.[45]

What the Research Says. *Homelessness among people with serious mental illnesses and substance use disorders can be prevented*. Discharge planning is one effective prevention strategy. Providing short-term intensive support services immediately after discharge from hospitals, shelters, or jails has proven effective in preventing recurrent homelessness during the transition to other community providers.[46]

Effective discharge planning should begin when an individual enters a hospital or jail. Elements of the discharge plan, which should be developed with the individual and be culturally appropriate, include housing, health care, treatment, income, employment, entitlements, personal support, and life skills training.[47]

In addition to discharge planning, studies show that subsidized housing helps prevent homelessness, even for people with serious mental illnesses and substance use disorders. Income support is also critical, since housing affordability is a function of both income and housing costs.[48]

Other Essential Services

Housing, treatment, and support services are the backbone of a comprehensive system of care for people with serious mental illnesses and substance use disorders who are homeless or at risk of becoming homeless. But these evidence-based and promising practices must be offered as part of a full range of services that are appropriate, accessible, and acceptable to consumers and recovering persons. The services noted below respond to specific needs of vulnerable individuals.

The hallmarks of these services are *outreach, choice, and ongoing support*. Some of the services, such as psychosocial rehabilitation and supported employment, were designed for people with serious mental illnesses and have been adapted for individuals who are homeless. Other programs that were designed for people who are homeless also serve people who have serious mental illnesses and substance use disorders. All of these efforts help prevent or end homelessness.

Primary Health Care

As noted previously, people with mental and addictive disorders who are homeless are at risk of both minor and life-threatening diseases, including diabetes, liver disease, tuberculosis, and AIDS. Life on the streets makes it difficult to receive appropriate care.

Because of their low incomes, the high cost of health care, and inadequate private health insurance, most people with serious mental illnesses rely on Medicaid, Medicare, and other government programs to provide mental health treatment, medications, and general medical care. People with primary substance use disorders are ineligible for Supplemental Security Income (SSI) and Medicaid, which both increases their risk of homelessness and makes it especially difficult for them to get medical care once they become homeless.

Further, people with serious mental illnesses who become homeless may be unable to enroll in these programs or continue to receive their benefits. As a result, they frequently use such high-cost services as emergency room and inpatient care. When they present in emergency rooms, they are at increased risk of psychiatric hospitalization, where their medical conditions may prolong their stay. Their debilitated condition also makes them more vulnerable to attack.[49]

Special health care programs designed for people who are homeless feature outreach and intensive case management to address an individual's full range of needs. These include the Health Care for the Homeless (HCH) program, administered by the Health Resources and Services Administration's Bureau of Primary Health Care in the U.S. Department of Health and Human Services.

HCH programs, many of which serve individuals who have serious mental illnesses and substance use disorders, are designed to be comprehensive, accessible, and culturally competent in an effort to help patients exit homelessness.[50] Many of these programs use mobile, interdisciplinary treatment teams to reach people on the streets or in shelters rather than requiring facility-based care.

Trauma-Sensitive Services

Health care providers working with people who are homeless must screen for and address trauma, including past and ongoing physical and sexual abuse. Individuals unable or unwilling to speak about the trauma they have experienced may present with somatic disorders such as headaches and backaches. Untreated trauma complicates the treatment for mental illnesses and substance use disorders and leaves individuals at risk for recurrent homelessness.[51]

Alcohol and Drug Abuse Services

The goal of substance abuse treatment for people who are homeless is to prevent, deter, reduce, or eliminate substance use and addictive behaviors. Treatment services may include outreach, counseling and education, case management, day programs, detoxification, and self-help and peer support activities.[52] These services may be

provided in outpatient settings and alternative living arrangements such as institutional settings and community-based halfway houses.

Substance abuse treatment is particularly critical for individuals with co-occurring mental disorders. A recent study revealed that among homeless clients with co-occurring disorders, those who reported extensive participation in substance abuse treatment showed clinical improvement comparable to or better than those individuals without co-occurring disorders.[53]

Mental Health and Counseling Services

People who are homeless must have access to a full range of outpatient and residential mental health and counseling services. These may include crisis interventions, individual supportive therapy, family or group therapy, medication management, and therapeutic approaches that address multiple problems. As noted previously, access to coordinated treatment for co-occurring mental illnesses and substance use disorders is also necessary and superior to other approaches for reducing alcohol and drug use, homelessness, and the severity of mental health symptoms among people with co-occurring disorders.[54]

Psychosocial Rehabilitation

The terms psychosocial rehabilitation and psychiatric rehabilitation often are used synonymously and interchangeably. Typically, psychosocial rehabilitation refers to a range of services, exclusive of clinical treatment, designed to help individuals with serious mental illnesses recover functioning and integrate or re-integrate into their communities. Psychosocial rehabilitation programs may or may not include the specific technology of psychiatric rehabilitation.[55]

Psychiatric rehabilitation, as defined and developed by the Boston Center for Psychiatric Rehabilitation, is a well-tested approach to helping people with serious mental illnesses function with success and satisfaction in environments of their choice with the least amount of professional intervention possible.[56] According to the philosophy of psychiatric rehabilitation, *recovering is what people with psychiatric disabilities do; psychiatric rehabilitation is what helpers do to encourage the recovery process*.[57]

Because psychiatric rehabilitation is an approach and not a program model, it can be applied in a variety of settings or programs, including case management and vocational programs that serve people who are homeless. Typically, such programs focus on independent living and social skills training, psychological support to individuals and their families, housing, vocational rehabilitation, social support, and access to leisure activities. Psychiatric rehabilitation programs that serve people who are homeless may have an added emphasis on outreach and on building trusting relationships that will allow individuals to explore their choices and learn the skills they need to succeed.

Randomized clinical trials have shown that participants in psychiatric rehabilitation programs have fewer and shorter hospital stays and are more likely to be employed.[58] The emphasis on choice, on individual potential, and on real-world settings may be especially attractive to people with serious mental illnesses who are homeless and who have had prior negative experiences with professionally directed treatment programs. Indeed, studies of the use of psychiatric rehabilitation with people who are homeless indicate that this approach is successful at engaging disaffiliated individuals, expanding their use of human services, and improving their housing conditions, mental health status, and quality of life.[59]

Income Support and Entitlement Assistance

People who are homeless need adequate income to help them secure and maintain housing. With limited work histories, they frequently must rely on Federal income and entitlement programs, including SSI. But many are not enrolled. Outreach to people with serious mental illnesses, especially those who are homeless, is essential to help them negotiate the benefits application, eligibility, and appeals process. The goals of outreach include the following: [60]

- providing accurate information about disability benefits and work incentive programs;

- helping individuals gather the required personal, financial, and medical documentation or referring them to programs that provide this assistance; and
- helping individuals file an application and mount an appeal, if necessary.

In response to the need for knowledgeable advocates to help individuals navigate complex program requirements, the Social Security Administration (SSA) established a Benefits Planning, Assistance, and Outreach program, which is authorized to fund community-based outreach projects in every State. Outreach providers, trained by SSA, are knowledgeable about other Federal benefit programs, as well, including TANF (Temporary Assistance to Needy Families), Medicaid, and Department of Housing and Urban Development programs.

Knowledgeable case managers (including peer case managers) and clinicians can make an enormous difference in their clients' ability to obtain and maintain disability benefits. With the client's approval, case managers may request duplicate copies of SSA mailings, which is especially helpful for individuals who have difficulty understanding their responsibility and responding in a timely manner.

Case managers may also serve as representative payees for clients who need help managing their benefit checks, or who fear that checks sent to shelter addresses will be stolen. About 25 percent of individuals who receive SSI have a representative payee.

Employment, Education and Training

People with serious mental illnesses and substance use disorders, including those with histories of homelessness, want and need to work. For many, work helps them recover from their disabilities. Further, income from work may help individuals regain and maintain residential stability.[61] Also, adequate standards of living and employment are associated with better clinical outcomes.

However, the same factors that place people with serious mental illnesses at increased risk of homelessness are challenges to employment, as well.[62] These include symptoms of their illness, lack of housing, stigma and discrimination, and co-occurring substance use disorders. Likewise, people with substance use disorders exhibit problem behaviors that interfere with job success.

Therefore, people who are homeless need more services and support than traditional job training programs offer. Successful job training programs for people who are homeless include comprehensive assessment, ongoing case management, housing, supportive services, job training and job placement services, and follow-up.[63]

Employment program models that are effective for people with serious mental illnesses, including transitional employment, supported employment, and individual placement and support, must be flexible in how they define success and be prepared to work with individuals who are homeless over the long-term. A "work-first approach," as opposed to extensive pre-vocational training, can motivate a person who is homeless to address other problems in his or her life. This means that employment programs must strike a balance between requiring complete abstinence or freedom from symptoms and tolerating some substance use-related behaviors or psychiatric symptoms on the job.[64]

Because mental illness often manifests itself in late adolescence or early adulthood, people's education and career plans may be interrupted. Individuals re-entering school have similar support needs to people adjusting to a competitive work environment, including a full range of housing, health and mental health, and support services.[65]

Services for Women

Gender-specific programs have been shown to improve retention and outcomes for women in substance abuse treatment.[66] For example, a Los Angeles study that examined women treated in publicly funded residential drug treatment programs found that participants in women-only programs had more problems at program outset, but they spent more time in treatment and were twice as likely to complete treatment compared to women in mixed-gender programs.[67]

Too often, however, treatment is geared to men and conducted with little attention to women's needs. For instance, women often dislike the confrontational approach common to substance abuse treatment. Further, the specific needs of mothers with children often are not met in existing treatment programs. In particular, research on homeless mothers with substance abuse disorders indicates that the lack of childcare is a significant barrier for many women seeking treatment.[68]

Because physical and sexual abuse is so common among women who are homeless and those who have mental and addictive disorders, programs designed for women must include an active program of trauma recovery.[69] Women who have become homeless after fleeing a dangerous household need specialized residential assistance.

Low-Demand Services

As noted previously in this report, individuals with serious mental illnesses and substance use disorders who are homeless may initially be reluctant to engage in services. They may have had previous negative experiences with the behavioral health care system, lack the motivation to begin treatment, or be more concerned about their immediate needs for food, shelter, and income.

Experience has shown that flexible, low-demand services may accommodate individuals who initially are unwilling to commit to more extended care. The ultimate goal of such services is to increase an individual's motivation for treatment and engage them in more intensive services.[70] The need for such services was a major finding of the NIAAA Cooperative Agreement Program.

The Department of Housing and Urban Development recognized the need for low-demand services when it established its Safe Havens program for people who are homeless and have a serious mental illness. Safe Havens are a type of supportive housing that serves those individuals who, perhaps because of their illness, have refused help or have been denied or removed from other homeless programs. Individuals are not required to participate in treatment, but are expected, as they are ready, to re-engage in services and move to permanent housing with supports.

For individuals with substance use disorders, a sobering station is a low-demand setting that accepts people who are intoxicated and serves as a first point of contact with the human services system.[71] Likewise, the presence of chemical dependency staff in a shelter or drop-in center may introduce individuals to the availability of substance abuse treatment.[72]

Crisis Care Services

People with serious mental illnesses are in danger of becoming homeless when a crisis occurs, including a flare-up of their symptoms, other medical emergencies, family stress, or the loss of a benefit check or employment. This is especially true for people with co-occurring substance use disorders. Providers recognize the importance of being able to respond quickly to people in crisis, help them on-site if needed, and provide short-term crisis facilities to avoid unnecessary hospitalization and homelessness. Interdisciplinary, mobile crisis teams provide immediate assistance and may link individuals to community-based, respite care.[73]

Family Self-Help and Advocacy

As a result of their symptoms and behaviors, people with serious mental illnesses and substance use disorders often strain the resources of their families to help, and may become homeless as a result. Helping families cope with the difficult aspects of living with and providing ongoing assistance to their family members with serious mental illnesses may prevent these individuals from becoming homeless.[74]

If family members understand issues such as the cyclic nature of mental illnesses, possible side effects of medication, and what to do when symptoms flare, they often are able to help their relatives maintain residential stability. In some cultures, the family is considered critical to a person's recovery from substance use and mental disorders, and they should be incorporated into treatment, as appropriate.

Respite services give a much-needed break to the stressful responsibility of providing a home to a family member with serious mental illness. In addition to their vital role as caretakers, family members can be successful advocates for improved treatment, increased funding, and ongoing research and education designed to improve the lives of all people with mental and addictive disorders.

Culturally Competent Services

As noted previously, racial, ethnic, and cultural differences can determine how individuals define their problems, how they express them, whether or not they seek help, from whom they will accept help, and the treatment strategies they prefer.[75] Practitioners, too, perceive clients through their own cultural lenses.

The basic tenets of cultural competence—*accepting differences, recognizing strengths, and respecting choices*—are critical to providing appropriate services to people who are homeless, especially those who have serious mental illnesses and substance use disorders. While homeless people do not represent a separate culture, per se, they have made adaptations to their circumstances that may affect the choices they make.[76] For example, behavior that may appear dysfunctional to the clinician may be adaptive for life on the streets.

Agencies that offer culturally adapted services share common strategies. They match clients with providers who have the same language and culture; provide services in minority communities; offer flexible hours and walk-in services; include families in treatment, where appropriate; and allow clergy and traditional healers to participate in the treatment process if the client desires.[77]

Jail Diversion Programs

People with serious mental illnesses and substance use disorders who are homeless have frequent contact with the legal system, both as offenders and as victims. The mental health, substance abuse, and criminal justice systems can collaborate to help divert people with mental and addictive disorders from jails and prisons into appropriate treatment. Individuals can be diverted from the criminal justice system before or after charges have been filed (pre-booking and post-booking, respectively).

Drug courts are one model that shows increasing promise for keeping non-violent offenders with substance use disorders from cycling in and out of jails and prisons. Drug courts combine treatment with intensive judicial supervision, mandatory drug testing, and escalating sanctions to help people break the cycle of addiction and the crime that often accompanies it. Individuals also receive such necessary services as education or job skills training. A study of drug courts in California showed that participants had severe multiple addictions and high rates of homelessness.[78]

Research shows that drug courts have an impact on both drug use and recidivism. A National Institute of Justice evaluation of the nation's first drug court in Miami showed a 33 percent reduction for re-arrests for drug court graduates, compared to other offenders with substance use disorders. Fifty to 65 percent of drug court graduates stop using drugs.[79]

Mental health courts based on this model are being developed to divert people with serious mental illnesses into treatment. An evaluation of the first 2 years of the Seattle Mental Health Court found that the target population experienced a decrease in criminal justice involvement and an increase in mental health treatment engagement.[80]

Diversion programs can't exist in isolation. They must be part of a comprehensive array of other jail services—including screening, evaluation, short-term treatment, and discharge planning—and must be integrated with community-based mental health and substance abuse treatment, housing, and social services.[81] So-called "boundary spanners" can bridge the two systems and serve as a liaison among mental health and drug courts, local police, and treatment providers.[82]

Putting the Pieces Together

None of the services highlighted in this section is effective in isolation. Research and practice for more than a decade indicate clearly that, to be effective for people with serious mental illnesses and substance use disorders who are homeless, *the individual service components must be coordinated in a comprehensive, integrated system of care.*

Integration is easier said than done. Fiscal, programmatic, and legislative constraints impact the ability of individual communities to achieve effective levels of integration

Essential Service System Components
Evidence-Based and Promising Practices
Outreach and Engagement
▪ Meets immediate and basic needs for food, clothing, and shelter.
▪ Non-threatening, flexible approach to engage and connect people to needed services.
Housing with Appropriate Supports
▪ Includes a range of options from Safe Havens to transitional and permanent supportive housing.
▪ Combines affordable, independent housing with flexible, supportive services.
Multidisciplinary Treatment Teams/Intensive Case Management
▪ Provides or arranges for an individual's clinical, housing, and other rehabilitation needs.
▪ Features low caseloads (10-15:1) and 24-hour service availability.
Integrated Treatment for Co-occurring Disorders
▪ Features coordinated clinical treatment of both psychiatric and substance use disorders.
▪ Reduces alcohol and drug use, homelessness, and the severity of mental health problems.
Motivational Interventions/Stages of Change
▪ Helps prepare individuals for active treatment; incorporates relapse prevention strategies.
▪ Must be matched to an individual's stage of recovery.
Modified Therapeutic Communities
▪ View the community as the therapeutic method for recovery from substance abuse.
▪ Have been successfully adapted for people who are homeless and people with co-occurring mental disorders.
Self-Help Programs
▪ Often include the 12-step method, with a focus on personal responsibility.
▪ May provide an important source of support for people who are homeless.
Involvement of Consumers and Recovering Persons
▪ Can serve as positive role models, help reduce stigma, and make good team members.
▪ Should be actively involved in the planning and delivery of services.
Prevention Services
▪ Reduce risk factors and enhance protective factors.
▪ Include supportive services in housing, discharge planning, and additional support during transition periods.
Other Essential Services
Primary Health Care
▪ Includes outreach and case management to provide access to a range of comprehensive health services.
Mental Health and Substance Abuse Treatment
▪ Provide access to a full range of outpatient and inpatient services, e.g., counseling, detox, self-help/peer support.
Psychosocial Rehabilitation
▪ Helps individuals recover functioning and integrate or re-integrate into their communities.
Income Support and Entitlement Assistance
▪ Outreach and case management to help people obtain, maintain, and manage their benefits.
Employment, Education and Training
▪ Requires assessment, case management, housing, supportive services, job training and placement, follow-up.
Services for Women
▪ Programs focus on women's specific needs, e.g., trauma, childcare, parenting, ongoing domestic violence, etc.
Low-Demand Services
▪ Helps engage individuals who initially are unwilling or unable to engage in more formal treatment.
Crisis Care
▪ Responds quickly with services needed to avoid hospitalization and homelessness.
Family Self-Help/Advocacy
▪ Helps families cope with family members' illnesses and addictions to prevent homelessness.
Cultural Competence
▪ Accepts differences, recognizes strengths, and respects choices through culturally adapted services.
Jail Diversion
▪ Features strategies to help divert people from jails and prisons into appropriate treatment.

**Section 2: Establishing a Comprehensive, Integrated
System of Care**

People with mental and addictive disorders who are homeless need multiple services, including housing, health care, mental health and substance abuse treatment, income supports and entitlements, life skills training, education, and employment. These services typically are provided by multiple agencies in different systems, leaving individuals to coordinate their own care. They may receive duplicate services at multiple agencies or no services at all.

The concept of integrating human services to improve outcomes for individuals with multiple and complex needs is not new. For more than 30 years, active efforts to integrate human service systems have been called by such names as community integration, comprehensive services, community support systems, and a continuum of care.[83] In its 1992 report, *Outcasts on Main Street*, the Federal Task Force on Homelessness and Severe Mental Illness set as a goal for the nation, "an integrated service system for homeless people with severe mental illness."[84] Clearly, progress has been made, but much remains to be done.

Systems integration efforts have taken on special urgency in an era of increasing needs and limited resources. Contemporary systems integration efforts are driven by several important factors. The relaxation of some Federal program regulations—through block grants and special waivers, for example—creates opportunities to promote integrated services. In addition, some Federal/State programs, including Medicaid managed care and welfare reform, may prompt collaboration among diverse agencies in order to meet mandated financial objectives and client outcomes.[85]

The Definition of Systems Integration

At its most basic, systems integration is designed to change service delivery for a defined population and involves fundamental changes in the way agencies share information, resources, and clients.[86] In particular, systems integration focuses on reducing barriers, coordinating and improving existing services, and developing new programs to improve the availability, quality, and comprehensiveness of services.[87]

Systems integration efforts require the creation of formal relationships between agencies within a system and among agencies across systems. Systems integration cannot succeed without an emphasis on integrated services, as well.[88]

The Creation of a Seamless System of Care

The ultimate goal of systems integration activities is to improve outcomes for people with mental and addictive disorders who are homeless. To do so requires creating a system of care that is seamless to the individuals being served. Indeed, full integration assumes a system-wide policy that makes "any door the right door" to receive needed treatment and services. This means that people with serious mental illnesses and substance use disorders who are homeless must be able to enter the service system through any service door, be assessed, and have access to the full range of comprehensive services and supports they want and need.[89]

This approach challenges the way in which systems with different funding streams, philosophies, and missions typically offer services. However, by responding collaboratively to address the multiple needs of people who are homeless, service systems benefit from a more efficient use of resources. Individuals benefit from client-centered services that place the burden of coordination on the systems serving them.[90]

Barriers to Integrating Services

Despite distinct advantages to both systems and clients, the barriers to integrating service systems are both broad and deep. As one observer notes, "While everybody is in favor of coordination, nobody wants to be coordinated."[91]

Some specific system-level barriers to effective integration include the following:[92]

- well-established programs and a specialized work force;
- interagency turf battles;

- funding limitations;
- lack of technology and resources to support information needs;
- lack of available services;
- size and complexity of the service system;
- lack of political will and mechanisms to channel public support; and
- legislative and political opposition.

The tools to address these barriers include the key systems integration strategies and mechanisms highlighted below. Sometimes Federal or State regulatory, statutory, or budgetary requirements must be relaxed to make it easier for agencies to collaborate with one another. However, even small changes in the way agencies relate to one another can pave the way for greater cooperation on behalf of people with serious mental illnesses and substance use disorders who are homeless.

Key Systems Integration Strategies and Mechanisms

Successful systems integration efforts are based on all of the knowledge a community has gained. In particular, services should be recovery-focused, culturally competent, flexible and individualized, and client-centered. Further, the full array of services that individuals needed must be in place or created; it makes little sense to develop a seamless system of care when some of the pieces of the system are missing. For instance, the importance of making a range of safe, affordable housing options available cannot be overstated. Without housing, services and supports are not effective. Finally, individuals must be supported while making the transition among services (e.g., from transitional to permanent housing) or from an institution to the community.

Each of the specific steps outlined below is critical to making systems change a reality. The strategies required to carry out each step will vary depending on the local needs, resources, and priorities of a given community, however, those that have proven successful in other jurisdictions offer useful guidance.[93]

Develop the Infrastructure for Systems Change

Choose a Change Agent

A dedicated staff person brings energy and attention to the task of systems integration. This person should be capable of providing the leadership necessary to engage key stakeholders from all levels. Key leadership characteristics for such a person include "vision, entrepreneurship, political astuteness, a respect for diversity, and a talent for managing complexity."[94] The systems integration coordinator must be highly respected and independent of the key collaborators to avoid the impression of favoritism or imbalance of power.

Secure Adequate Resources

Money is a necessary, though not sufficient, ingredient of systems integration activities. Without some flexible funding or regulatory relief, systems integrators begin in a weak position.[95] The next chapter includes an overview of strategies to finance services for people with serious mental illnesses and substance use disorders who are homeless.

Build a Coalition of Key Stakeholders

Building a coalition of key stakeholders is critical to the systems change process. This group must include those with the authority to commit their organization and its resources to needed changes.[96] Such groups may vary in size and composition, organizational structure and process, and missions and objectives.[97] In general, however, coalition membership should be inclusive rather than exclusive and involve consumers and recovering persons in an active role.[98] Other important stakeholders might include those listed below.

- Executive branch leaders from State and local governments (e.g., governors, mayors).
- Agency heads from State and local departments of housing, mental health, substance abuse, health, Medicaid, welfare/social services, education, homeless services, transportation, labor, criminal justice, etc.
- Health, mental health, substance abuse and homeless assistance providers.
- Faith and community-based organizations.
- People who are homeless or formerly homeless.
- Consumers and recovering persons and their families.
- Members of the business community.
- Advocacy groups.

The U.S. Department of Health and Human Services has sponsored a series of State-level Policy Academies designed to develop an infrastructure for systems change. The Academies create or reinforce relationships among key stakeholders in selected States (e.g., the governor's office, State legislators, key program administrators, and stakeholders from the public and private sectors) who can work together to improve access to mainstream services for people who are homeless.

Nurture the Coalition and Continue to Form Partnerships

Relationships with key stakeholders must be nurtured in order to engage them fully in the process. Other important parties may be identified along the way and should be similarly engaged.[99] Once the group is established, members can begin to build relationships and develop a common language, define their mission, and create a structure for working together.[100]

Building a coalition is a means to systems change, but not an end product. Collaborative planning is an ongoing process that involves building new relationships and securing commitment from all players to carry out a community's plan to address homelessness. In forming new or re-evaluating old relationships, individuals must be aware of their own preconceived notions about the services and resources of other stakeholders and be open to understanding new or different perspectives. Engaging in active listening and focusing on ideas rather than people supports honest expression of ideas and sharing of information.[101]

Engage in Strategic Planning

Developing a formal plan for action is a critical ingredient of the collaborative planning process.[102] This is best accomplished by strategic planning, as summarized in Table 5.1. Engaging in this process helps delineate the parameters of the systems integration effort and set specific goals and objectives. Without such a plan, systems integration efforts have no direction, no means to evaluate their progress, and no basis on which to build trust.[103]

Define the Issue

Before a community can develop a plan to integrate care for people who are homeless, it must first be clear about what services it currently offers and where there are gaps or unmet needs. Data that indicate where people are being over- or underserved in the system, along with anecdotal examples that point to barriers or gaps in the system, should be openly discussed to help the group produce a shared definition of the problem.[104]

Such data may include "hard" data such as admissions and clinical encounter information from programs that serve people with mental and addictive disorders and people who are homeless. "Soft" information such as key informant interviews and focus groups with system stakeholders may also be considered.[105]

Create a Shared Vision

When the group has identified the problem or problems it wants to address (i.e., lack of discharge planning for individuals with mental and addictive disorders leaving a hospital or jail), members can develop a shared vision or mission statement for creating an integrated service system.[106] In creating this vision, the group should not be constrained by the system's current configuration or resources. Rather, the vision should represent the "preferred future" of the system or what it could look like if systems integration were achieved.[107] Ultimately, a vision statement should be simple, concise, and clear and should immediately engage all parties.[108]

Develop a Plan

When the group has defined its mission, it should develop a formal plan that specifies recommendations for change. Such a plan documents the specific goals, objectives, and strategies for making the vision a reality. For example, the group may decide that it needs to implement formal discharge planning policies to keep people with serious mental illnesses and substance use disorders from becoming homeless when they leave a jail or psychiatric hospital. The plan should also assign responsibilities for tasks and set timeframes for completion.[109] Procedures for measuring outcomes to ensure accountability should be built in, as well.

Implement the Plan

A number of mechanisms may be used to accomplish a community's specific goals, as highlighted in the following table. These include co-location of services, pooled or joint funding, and streamlined application procedures. For example, a homeless services provider may station a case manager at the jail to help create discharge plans for people with serious mental illnesses and substance use disorders who are at risk of homelessness.

Many of these strategies have been successful in promoting systems integration in other communities, including those involved in the ACCESS (Access to Community Care and Effective Services and Supports) demonstration program, administered by the Center for Mental Health Services. Findings from the ACCESS evaluation indicate that successful implementation depends, in part, on the specific strategies selected. Certain mechanisms, such as the use of interagency agreements, appear to be easier to implement. Others, including the development of interagency management information systems or the establishment of common eligibility criteria, require time and a well-functioning infrastructure to implement successfully.[110]

The Strategic Planning Process	
STEPS	**ACTIVITIES**
Define the Issue	Identify existing services and resources and gaps or unmet needs in the system. Share and discuss data to reach agreement on the definition of the problem or issue.
Create a Shared Vision	Use imagination and brainstorming to create a "preferred future." Don=t be constrained by current resources.
Develop a Plan	Identify goals/objectives and strategies for achieving them. Assign responsibility for tasks necessary to implement each strategy. Establish timeframes for completion.
Implement the Plan	Carry out selected strategies/mechanisms as assigned.
Monitor Progress	Collect outcome data and monitor progress. Allow for ongoing input and refinement of strategies, as necessary.

Monitor Progress

Collecting and analyzing data will highlight incremental improvements as well as long-term accomplishments.[111] For example, a community might measure the number of days homeless after leaving jail as an indicator of successful discharge planning efforts for people with serious mental illnesses and substance use disorders at risk of homelessness. This information can also be used to make mid-course corrections in the implantation plan, as necessary.

Successful evaluation efforts require the establishment of guidelines for consistent data collection, performance standards, and reporting. Quality assurance can be tied to funding (e.g., written into contracts) as a means of ensuring compliance. Strategies for evaluating outcomes are described further in Chapter 7.

Implementation Strategies
Co-locate services—Provide multiple services in a single location for "one-stop shopping" for users.
Train and cross-train staff—Train one's own staff or staff from other agencies about a particular topic or agency's services.
Create interagency agreements or memoranda of understanding—Enact agreements among agencies, either formal or informal, that specify arrangements to share information, referrals or coordinate services
Implement interagency management information systems (MIS)—Develop MIS and computerized client tracking systems that link agencies, promote information sharing, simplify referrals, and facilitate clients' access to services.
Use pooled or joint funding—Try layering or combining funds to create new services or resources to support interagency activities.
Develop uniform applications, eligibility criteria, & intake assessments—Create a standard process or form used by multiple agencies that an individual completes only once.
Use interagency service delivery teams—Establish interdisciplinary teams from different agencies that address the multiple needs of clients in an integrated manner.
Make some flexible funding available—Use non-categorical funding to fill the gaps in services, purchase expertise, or leverage additional resources.
Consider special waivers—Apply for or enact waivers in regulatory, statutory, or budgetary requirements that reduce barriers and promote access to services.
Consolidate programs or agencies—Combine multiple agencies or programs under a central administrative structure to reduce fragmented services.

Seek Technical Assistance

The value of technical assistance at critical junctures deserves mention as an important strategy in a successful systems change initiative. Communities sometimes need an outside facilitator to help with the strategic planning process or an evidence-based practice expert who can advise on implementing a specific service component.[112][113] It may also be helpful to visit and talk to others who have already implemented a similar approach or system component in another community. Being able to identify specific technical assistance needs and to seek help early in the process can help communities avoid losing the momentum needed to achieve lasting change.

Endnotes

Endnotes

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